



Planning For Hospital And Health Facilities

JOHN W. CRONIN, M. D.*

WASHINGTON, D. C.

Each hour, each moment we stand on the threshold of the unknown. This statement holds true for each of us as individuals and also for all of us as a Nation. It is in times such as these that our real worth as free men becomes manifest.

The foundation upon which all of our great progress as a Nation has been built has been our ability to plan for the future. In isolated instances the planning has been done by a single individual, but in the vast majority of times the planning has been the result of the work of many individuals, competent in many skills, getting together, working together, sharing trials and tribulations, but ever pushing forward to achieve the common goal for the betterment of all. That is democracy in action.

All planning is based on recognition of need. One of the greatest needs in our whole country today is adequate health services for our people. We need to maintain and improve the quality of our health services. Equally as important we must extend the scope of these services so that they will be available to those in need of them. This is true in time of peace, but in time of potential war—hot or cold—it is imperative that the health resources of the Nation be mobilized to meet any catastrophe—great or small. Today atomic, bacteriological, radiological catastrophes are a concern of many of our communities. Those of us who deal with services to our fellow men in time of illness have an even greater duty during the preparation for the defense of our Country.

It is well to take stock of some of the important aids available to the Nation in building up our health resources.

In 1946, by the action of the 79th Congress and the President, Public Law 725 established the Hospital Survey and Construction Program. This program, known

popularly as the Hill-Burton Program, was designed basically to assist the states to provide needed hospital and health facilities in needy areas. These areas were primarily rural. The mechanics of this Act have proven it to be one of the most soundly conceived statutes ever enacted by Congress in providing for local, state and Federal cooperation in providing hospital services. It is administered on the state level with the local community retaining the incentive for local initiative and local operation of the completed non-profit, non-discriminatory, community service type of facility. An inventory and analysis by the state of the existing facilities and definition of the need for additional facilities is required before Federal funds become available on a matching basis for construction purposes.

The State establishes the percentage of Federal funds to be made available annually for each project in its borders. The total amount of Federal funds granted to the respective States is determined by a formula in the Law. The controlling factors, however, are population and per capita income of the State.

In 1949 the basic law was amended to include Federal aid for research in the field of hospital services. An appropriation to implement the amendment was under consideration at the outbreak of the hostilities in Korea. With the increased demands on the distribution of our Federal funds there has been no appropriation made available for this type of research.

As of July 31, 1951 a total of 467.5 million dollars has been appropriated for hospital and health center construction. This has made possible the approval of 1600 projects which will provide 77,000 additional hospital beds. An analysis of all the State plans shows that there are in existence today approximately 1,100,000 acceptable hospital beds and a deficit of nearly 830,000. In other words we have only about 54 percent of our needed hos-

*Chief, Division of Hospital Facilities, Public Health Service.

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pital plant in this country at this time.

Of the 1600 approved projects, 475 are completed and rendering a community service, 1000 are under construction and 125 are still in the planning stage. Total construction costs are estimated at slightly more than 1 billion, two hundred million dollars. The Federal share is about 36 percent of this amount.

Of all the projects approved, nearly three-fourths are for general hospitals. This includes new hospitals as well as additions, alterations or remodeling of existing hospitals. Next in order are public health centers—about 15 percent; then mental hospital projects—about five percent; tuberculosis projects—3 percent, with only about 1 percent for chronic disease facilities.

It is apparent that most of the emphasis has been on general hospital facilities. About 55 percent of the general hospital projects are for completely new hospitals. Most of the new hospitals are being built in small towns and in the smaller cities; nearly 61 percent of the new general hospitals are located in towns of less than 5,000 population. Only 7 percent are in cities of more than 50,000 people.

This to me points up the Providential nature of the Hill-Burton Program at this time. There is a duality of purpose noted. I pose the question, "Can not these Hill-Burton Hospitals be regarded as evacuation destinations for our potential target areas." I hope we will never be called upon to put this statement to a test, but we may be. It certainly was not our original purpose.

Of the total Federal funds made available \$15,551,132 has been allocated to Kentucky. State aid to communities has also been granted. To date 47 projects have been approved. 28 are for general hospitals of which half are completely new facilities. The balance is made up of projects that provide for the replacement of old buildings, or for additions or alterations to existing general hospitals. Six projects are located in tuberculosis sanatoria, and four provide additional psychiatric facilities. Seven health centers have been constructed, three of which are combined with new general hospitals.

Two of the projects are located in Hopkinsville and others in this section are at Clinton, Cadiz, Princeton, Owensboro and Leitchfield. With the exception of

Owensboro, these projects will provide completely new facilities.

The provision in the Hill-Burton Act for survey and planning has proved to be one of the soundest features of the law. Each community fits into a pattern of service as outlined in the State Plan. The community must determine the size of the facility that can be supported and the services to be included. The local community planning features are one of the major reasons why the Public Health Service believes that a program for what we now call defense impacted areas, with increased populations, should follow the Hill-Burton concept. Service at the local level is the objective of the program for war impacted areas. Therefore, advice from the communities where the affected people live is essential. Conversely, State and Federal advice to local planning groups is important if the planning is to be really effective. Those involved at all levels should take part in it, not simply be brought into the program after the plans are made.

In addition to the Hill-Burton Program, with its obvious limitations for hospital construction in war impacted areas there are several action programs designed to provide assistance.

The Federal Civil Defense Act does not contemplate the making of grants for hospital construction. It does provide for the incorporation of shelter areas or other construction designed to provide protection of the occupants against enemy attack. Funds, however, are very, very limited.

The bill sponsored by Senator Maybank of South Carolina and Representative Spence of Kentucky known as the Defense Housing and Community Facilities and Services Act was passed by this 82nd Congress and signed by the President. Title III of this Act relates to Community Facilities and resembles in some respects the Lanham Act of World War II. The provisions of this Act include hospital facilities and services for the care of the sick, as well as facilities for water, sewage, sanitation and other community facilities. Federal funds in the amount of 60 million dollars are provided for the construction, maintenance or operation of community facilities. In the case of assistance for hospital construction these funds will be available only if funds are not available under the Hill-Burton Act.

This legislation also provides that maintenance and operation payments will not exceed the portion of the maintenance and operation expenses attributable to the "National Defense Activities in the area." The Act also specifies that the function, powers and duties with respect to health, refuse disposal, sewage treatment, and water purification shall be exercised by and vested in the Surgeon General of the Public Health Service. This latter proviso properly relates the health activities to those existing in regard to the Hill-Burton program. The success of this legislation depends entirely upon local, State and Federal cooperation and coordination of hospital and health services—the kind of cooperation which has proven so eminently effective to date.

The communities in western Kentucky are affected by the defense activities currently taking place at Paducah, Camp Breckenridge, Camp Campbell, Fort Knox and in the T.V.A. areas. It is important that plans be made at once for health resources in this general area. Based on successful planning on other areas this may be accomplished as follows:

First, form a Planning Committee.

Community health planning has many facets. There is need for teamwork among many groups. The key groups are the medical societies and the trained and experienced local public health officials. BUT these cannot do the job alone. The team must have representatives of volunteer health agencies, other professional and educational groups, organizations concerned with fields related to health, and all those groups which might be called consumers of health services.

Second, gather factual data on existing resources and need.

It is estimated that the peak population influx is expected to increase the population of affected communities in this section of Kentucky by about 50 percent. Hopkinsville has already had at least a 12 percent increase. Problems in sanitation, tuberculosis and venereal disease control have already arisen. Hopkinsville has a sanitary land fill system of refuse disposal but other communities in this area have less adequate systems.

Such matters as the role of insects as disease carriers and their control must always be considered.

Resources across state lines must be considered. For example, a 125 bed hos-

pital is being constructed in Clarksville, Tennessee, which may provide for patients from this area if adequate arrangements are made. Data should also be obtained on the provisions needed for mental, tuberculosis and chronic disease patients.

The Public Health Service in cooperation with Commissioner Bruce Underwood of the Kentucky State Health Department made a survey for the Atomic Energy Commission in February 1951 and recommended that 80 hospital beds and an additional nurses' residence were needed to care for the influx population in Paducah. These beds were proposed in addition to the expansion planned for Riverside Hospital under the Hill-Burton Program. It is possible that a 100 bed Baptist Hospital, begun some years ago, may be completed. If the fund drive for the Baptist Hospital is successful and it is erected, will there be a need for additional beds, and if so, how many?

These are typical questions for which answers must be sought by the local communities.

Third, bring to the attention of local community professional and lay groups for the joint study and solution of the problems and for the correlation of all programs and services affecting health—preventive, therapeutic, environmental.

One successful method of filling in gaps in hospital services is by coordination and cooperation among hospitals. There is good evidence that the small hospital cannot—by itself—provide all of the services needed by the people it serves. A solution is to develop relationships among hospitals whereby the larger and more completely equipped can provide the smaller with the needed services.

The concept of a regional hospital coordination system includes many lines of affiliation and sharing among hospitals. For example, such a system envisions interne and resident physician services on a rotating basis to hospitals which otherwise would not have the advantage of such services; (internes for small hospitals are a rare commodity today); the provision of consultation and part time specialist services, including radiology, pathology and other diagnostic services to small institutions; clinical conferences in small community hospitals; educational courses for all classes of hospital personnel; postgraduate training of physicians from small communities; provision for the search for knowledge related to

modern hospital practice in administration and clinical services; stimulation and exchange of information on improved hospital administrative methods; group purchasing; uniform medical records and bookkeeping systems; joint planning of hospital and public health programs. All these are directed toward better patient care and when combined with a proper and adequate hospital licensure law will accomplish better patient care. Coordination of facilities and services indicates the need for a regional planning committee composed of representatives from each of the community planning bodies.

Out-patient departments may be used as a means of alleviating hospitalization in communities where the demand for beds exceeds the supply. Home care programs have aided in this regard. Out-patient service provides one of the best means for hospital participation in preventive medicine, particularly in the fields of mental illness, venereal disease and tuberculosis. Rehabilitation services started early and adequately conducted shorten hospital stay and permit return of the individual to an economically competent status. The results of this type of service pay big dividends, especially in state and other governmentally supported institutions.

Fourth, interpret the findings to the public.

Constant efforts should be made to increase public participation in planning. In this way valuable health education may be accomplished relative to the proper use of existing services and facilities.

Fifth, develop methods of effective implementation of the plan.

The best method to assure this is through education of all the people in the community of the need for it. Planned publicity of the educational type, combined with planned public relations of a high order, are of great value.

The objective of community planning should be to make available to every individual the curative and preventive benefits of medical science at its best. Preventive medicine is a function of every physician and every hospital. Diagnosis, treatment, restoration to health, rehabilitation, prevention of disease and health promotion and health maintenance are the obligations assumed by every physician. The hospital should be the health center of the community. It is the mobilization depot of modern medical science. The practice of medicine should not be confused with the business of medicine by the physician or the hospital administrator; however, the relationships must be understood.

A community health program which combines curative and preventive aspects to attain health promotion and health maintenance will be not only of inestimable value to the defense effort but also will pay great dividends to the sick and the well at any time. The accomplishment of this objective will require dynamic leadership, imagination and cooperative effort of the highest order.

In closing I think it is appropriate to recall the official motto of this great industrial and agricultural State "United We Stand, Divided We Fall."